TABLE 2. Symptom Severity Scale (SS)
Check severity of each problem, then total score (0-12).

	No problem (0)	Mild problem (1)	Moderate problem (2)	Severe problem (3)
Fatigue				
Cognitive problems				
Waking un-refreshed				
Somatic symptoms*				

***Somatic symptoms:** How many of the 41 symptoms listed below does the patient have? Then score 0 to 3 on the *total symptom burden*.

1) Muscle pain
2) Irritable bowel syndrome
3) Fatigue/tiredness
4) Thinking or remembering problem
5) Muscle weakness
6) Headache
7) Pain/cramps in the abdomen
8) Numbness/tingling
9) Dizziness
10) Insomnia
11) Depression
12) Constipation
13) Pain in the upper abdomen
14) Nausea
15) Nervousness
16) Chest pain
17) Blurred vision
18) Fever
19) Diarrhea
20) Dry mouth
21) Itching
22) Wheezing
23) Raynaud's phenomenon
24) Hives/welts
25) Ringing in ears
26) Vomiting
27) Heartburn
28) Oral ulcers
29) Loss of/change in taste
30) Seizures
31) Dry eyes
32) Shortness of breath
33) Loss of appetite
34) Rash
35) Sun sensitivity
36) Hearing difficulties
37) Easy bruising
38) Hair loss
39) Frequent urination
40) Painful urination
41) Bladder spasms

Scale symptoms as: 0= few or no symptoms, 1=mild number of symptoms, 2= moderate number of symptoms, 3=great number of symptoms. Then add this number to the "somatic symptoms" in the Symptom Severity Scale table above.

question as to whether one would now be justified in making a diagnosis of FM without any examination. In other words, can FM be a disorder defined solely by symptoms(similar to DMSM-defined psychiatric diagnoses?) It is relevant to note that the discussion does stress the need for "an appropriate clinical assessment," but I have a concern that this will inevitably be omitted by some time-stressed physicians. It is my opinion that any potential criteria should demand a carefully structured physical examination and not be left to the physician's whim. The management of FM demands an assessment of all other potential sources of pain—especially those of musculoskeletal origin, such as osteoarthritis and soft tissue pain. In regards to the latter, an evaluation of active myofascial pain trigger points is especially relevant. It is now apparent that the 1990 ACR-defined tender points are, in fact, typical myofascial trigger points in most locations[6] and that they are an important contributor to the FM pain experience.[7,8] These relatively recent research findings have cast FM tender points in an important new light and so they need to be carefully considered before the "baby is tossed out with the bathwater."[9] Thus, while it may not be a strict requirement for the new preliminary diagnosis, it is my opinion that a competent evaluation of a patient with probable FM should include not only a examination of the 1990 ACR tender points but also all potential myofascial trigger points, as dictated by the history. It is also worthy of comment that the controls in this study excluded patients with inflammatory rheumatic disorders, thus the specificity of these preliminary criteria is not known. For instance a patient with rheumatoid arthritis may well be "preliminary" criteria positive, but should be excluded by a thorough clinical evaluation. Whether a patient can have concomitant RA and FM (as occurs in about 20% of cases) with use of the new criteria is not clear.

In general, I consider these preliminary diagnostic criteria to be just that—"preliminary." It is a good first step in trying to come up with easily applied diagnostic criteria and doing away with the need to define FM purely on the symptom of widespread pain and a certain number of tender points. I certainly applaud the need to incorporate symptoms other than pain in the diagnosis of FM. But I have reservations about basing the diagnosis purely on symptoms, as this makes it a diagnosis that can easily be "faked" and may eventually lead to the designation of FM as a "wastebasket diagnosis"—as was often done before the ACR classification criteria were introduced in 1990.

Suggested Improvements

I believe these preliminary symptom criteria can be improved upon. For instance, the duality of the diagnostic logarithm make them rather clumsy to apply and may, in reality, be defining two subgroups of chronic pain. I would strongly recommend a reconsideration of the role of tenderness as part of any new diagnostic recommendations. While I endorse eliminating the 1990 ACR tender point criteria, I favor replacing them with a more objective and/or simpler measure of tenderness. What this should be remains to be determined. But there have been studies that suggest the feasibility of using something as simple as assessing the pain threshold during the taking of blood pressure with a sphygmomanometer cuff[10] or the more sophisticated computerized cuff pressure algometry, as described by Jespersen and colleagues.[11] Harden and others have reported that three tender points provide as much classification accuracy as the use of all 18 points.[12] Another alternative is to further explore the increased reactivity of FM patients (so called "central sensitization") in a relatively simple procedure known as nociceptive reflex testing[13]—a test that can be administered in most units performing routine EMG/NCV tests.[14] When all is said and done, the essence of fibromyalgia combines pain and stiffness along with other characteristic symptoms (especially fatigue, un-refreshing sleep and general reactivity) with an undue tenderness to touch.[15] The recent OMERACT consensus, reporting on the key symptom domains that should be assessed in FM, recommends that "tenderness" be included as a separate domain and notes that: "physiologically, this would be logical because spontaneous and evoked pain involve different pathways. Furthermore, it mirrors the need to assess patient-reported pain and tender joint count in rheumatoid and psoriatic arthritis."[16]